

Spectrum Radiology Associates PLLC
MAMMOGRAPHY INTERVIEW FORM

Date: _____

File No: _____

Name: _____

Date of Birth: _____

PREVIOUS MAMMOGRAMS: (Circle) Yes No

When: _____ Where: _____

PERSONAL HISTORY: Last Menstrual Period: _____ Current Weight _____
 No potential for pregnancy exists (please initial) _____

Are you currently taking hormones? No Yes If yes, for how long? _____

Are you **currently** experiencing any of the following? (Please specify)

	No	Yes	Left	Right	How long
Lumps in the breast	_____	_____	_____	_____	_____
Changes in (please circle) skin; nipple; discharge	_____	_____	_____	_____	_____

Comments: _____

Have you ever been diagnosed with breast cancer?

No Yes Age at diagnosis _____

	Left	Right	Dates
Lumpectomy	_____	_____	_____
Mastectomy	_____	_____	_____

For Technical Use Only!			
	R	L	Date
Radiation	_____	_____	_____
Tamoxifen/Chemo	_____	_____	_____
Surgical	_____	_____	_____
Stereotactic/Core	_____	_____	_____
Cyst Aspiration	_____	_____	_____

Have you had any other previous breast surgery, implants, reduction or biopsy? (Circle) No Yes

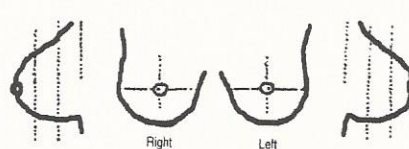
	Left	Right	Dates
Implants	_____	_____	_____
Reduction	_____	_____	_____
Biopsy	_____	_____	_____

Comments: _____

FAMILY HISTORY OF BREAST CANCER (Circle **AND** mark **AGE** at diagnosis) None

Mother _____ Daughter _____ Sister _____ Maternal Grandmother _____ Maternal Aunt _____

(FOR TECHNICAL USE ONLY)

Reason for exam :	Screening /Baseline		Diagnostic		Short term F/U		
			R	L	R	L	Full
Last CBE:							
Pt DOES NOT practice regular BSE							
+ / - _____ lbs							
Findings/ Technical notes:							
							
					Nipple retraction	Y	N
					Chronic New	R	L
					Mammo Pad	Y	N
					Tech _____		